To cure physician burnout, unburden doctors

By Rushika Fernandopulle, MD | July 13, 2016

The great sculptor Michelangelo was once asked how he created the Pieta, one of the greatest sculptures of its time. His answer was simple: "I just take a block of stone, and chip away everything that is not the Pieta."

As a primary care internist, I have strived to do exactly this for the past dozen years. Yet I have watched as more and more has been added to doctors' plates, burdening their days, distracting them from care, and turning physician burnout into what some have called an occupational health crisis.

In a recent Mayo Clinic review, more than 54 percent of physicians reported at least one sign of burnout — double that of the general population. The response was 20 percent worse than it was in 2011 when they last fielded the survey. More worrisome, 39 percent of physicians reported symptoms of depression, and a shocking 7.2 percent reported having experienced suicidal thoughts. As Steve Adelman wrote in this publication last month, "In the same way mining is unsafe for workers, healthcare is becoming an unsafe work environment."

Many are trying valiantly to tackle this problem by offering doctors support groups or coaching programs where they are taught how to say "no" to patients, colleagues and staff. But to truly address burnout, we don't need to add more to physicians' overflowing plates. We need to take things off.

The job of a doctor has always been difficult and stressful: patients come with myriad complaints fraught with emotional overlays. We make serious, real-time decisions daily with incomplete information, and live with the consequences (including the ever-lurking fear of real or frivolous malpractice suits).

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Not to mention the struggles to get paid for doing any of this. Each day comes with more and more forms to fill and boxes to check, along with pressures to generate more RVUs, meet increasingly complex meaningful use or quality bonus programs, and begin to figure out the ins and outs of participating in the proposed MACRA models.

We have turned our healthcare system into a set of complex transactions, where everything needs to be coded, sub-coded, and billed using increasingly

arcane sets of rules. The lunacy of the new ICD-10 codes (with codes for "bit by turkey for the first time", and "burn due to water skis on fire") and the documentation standards one needs to justify a 99214 visit are but a few mind-spinning examples.

But transactions have never healed anyone. And they aren't the reason any of us went into medicine in the first place. What heals and fuels our calling as doctors are relationships.

So at the company I co-founded, Iora Health, we've tried to chip away at the transactions and the noise that stand in the way of good care, and focus instead on the relationships that give medicine meaning.

We began at the source of the problem: the fee-for-service payment model. It's the wrong way to pay for primary care, so we stopped doing it. Instead, we contract with progressive employers, union trusts or health plans to pay us a fixed fee per patient or some version of purely value-based payment such as shared savings up to full risk.

Our doctors do no CPT coding, and never need to submit bills for payment. This allows them to see their patients through a relational rather than a transactional lens: here is a population of patients and they are our problem, and our job is simply to improve their health and keep them out of trouble — whatever it takes.

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Since we're aligned with our payers, we can also start to chip away the prior authorizations, concurrent review programs and other adversarial utilization management programs. Instead we can work with our payer partners to remove barriers to good care.

Finally, we surround doctors with a robust team. Each practice of two to three doctors also includes a clinical team manager, a behavioral health specialist, two operations assistants, and six or more health coaches, all of whom can work closely with the doctors to help patients follow through on their care plans. Moving these tasks to other talented and empathetic staff lowers cost and frees doctors to do what only they can do.

We have been doing this in 29 practices in 11 different markets, and it works. Patients love it: We regularly have a greater then 90 percent net promoter score, compared to 3 percent for the average primary care practice. We demonstrate much improved clinical outcomes, and dramatically lower hospitalizations and ER visits compared to matched control groups, leading to lower total healthcare costs. And, importantly, we have much happier doctors: over five years, we have had less than a 3 percent voluntary attrition rate.

Granted, not every medical organization will be able to focus solely on these types of payer contracts, or to avoid some of the regulatory requirements that don't apply to our patient groups. But the general principle — that our outdated, complex fee-for-service system is the root of the problem — could apply to healthcare organizations of any structure. Our model should give all healthcare organizations a lever with which to press the government for more simplicity, more common sense, and the kind of care patients are demanding.

Only when we step off the transactional track, and restore our focus on relationships that work, will healthcare begin to look like the Pieta we can envision.

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